## NOTICE OF PRIVACY - ACKNOWLEDGEMENT

We keep a record of the health care services we provide for you. You may ask to see, copy and/or correct that record. We will not disclose your record to others unless you direct us or unless the law authorizes or compels us to do so. For more information please contact our HIPAA privacy and Security Officer Tammy Matthews.

### Patient Authorization Form

I hereby authorize you to use or disclose the specific information described below, only for the purpose and to the parties also described below.

Description of the specific information to be used or disclosed:

_____

Person authorized to approve the release of information and the purpose of use:

_____

(*patient name or guardian* ) *(relationship to patient)*

Recipient of the information and relationship to patient:

_____

_____

This information is being requested for the following purpose (s):

_____

This authorization shall remain effective from date signed below until:_____

Patient Name:_____ _____

*(print)* *(signature)*

Relationship to Patient (if signed by personal representative of patient):_____

Date:_____